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OMB#: 0925-0584
Exp. xx/xx/xxxx

HCHS/SOL Visit 2 Participant Disability Screening Form

ID NUMBER:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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FORM CODE: PDE
VERSION: 1, 06/03/2014

Contact Occasion

0	2
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SEQ #

0	1
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ADMINISTRATIVE INFORMATION

0a. Completion Date (mm/dd/yyyy): //

0b. Staff ID:

Instructions: This disability screening form must be completed after informed consent administration and before the participant has their examination. Positive responses to Questions 1 – 6 should be noted on the Exam Itinerary Checklist for routing purposes during the visit.

Introductory Script for staff: Now I would like to ask you about difficulties you may have in usual activities of daily living:

A. Disability Status

1. Are you deaf or do you have serious difficulty hearing?

No 0

Yes 1

2. Are you blind or do you have serious difficulty seeing, even when wearing glasses?

No 0

Yes 1

3. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?

No 0

Yes 1

4. Do you have serious difficulty walking or climbing stairs?

No 0

Yes 1

5. Do you have difficulty walking one half mile (approximately 1 kilometer)?

No 0

Yes 1

6. Do you have difficulty climbing 10 stairs?

No 0

Yes 1

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Contact Occasion	0	2	SEQ #		
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7. Do you have difficulty dressing or bathing?

No 0

Yes 1

8. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping ?

No 0

Yes 1